DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

# TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

**FOR: HEALTH CARE FINANCING ADMINISTRATION**

1. TRANSMITTAL NUMBER: 0 2 — 0 0 9

2. STATE: GEORGIA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2002

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☐ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.250

7. FEDERAL BUDGET IMPACT:
a. FFY 2002 $ 8,046,779
b. FFY 2003 $ 32,514,441

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A pp. 10-~~58~~ 73

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A pp. 10-~~58~~ 73

10. SUBJECT OF AMENDMENT:
NURSING HOME RATE SETTING

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Mark Trail

13. TYPED NAME:
Mark Trail

14. TITLE:
Director, Division of Medical Assistance

15. DATE SUBMITTED:
July 31, 2002

16. RETURN TO:
Department of Community Health
Division of Medical Assistance
2 Peachtree Street, N.W.
Atlanta, GA 30303-3159

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED: 11/19/03

18. DATE APPROVED: 3/10/04

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 7/1/02

20. SIGNATURE OF REGIONAL OFFICIAL: Barbara Smith

21. TYPED NAME: Charlene Brown

22. TITLE: Deputy Director, CMSO

23. REMARKS: Per e-mail changes to include plan page 10-73

FORM HCFA-179 (07-92)

*Instructions on Back*

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – NURSING HOME SERVICES

## PART II - CHAPTER 1000

## BASIS FOR REIMBURSEMENT

1001. General

This chapter provides an explanation of the Division's reimbursement methodology.

1002. Reimbursement Methodology

A facility's Actual Reimbursement Rate is the amount the Division will reimburse to a facility for nursing services rendered to a particular eligible patient for one patient day and is calculated by subtracting Patient Income from Total Allowed Per Diem Billing Rate. The Actual Reimbursement Rate is always subject to prospective adjustment to effectuate the policies described in this chapter. In addition, it is subject to retroactive adjustment according to the relevant provisions of Chapter 400 and Section 504 of Part I of this manual.

1002.1 Definitions

a. Patient Income is that dollar amount shown on the Summary Notification letter issued by the Department of Family and Children Services (DFCS). Refer to the Billing Manual for Nursing Facility Services for information about the Summary Notification letter. The patient's income is deducted in full from the Medicaid reimbursement rate until the income has been exhausted.

b. Total Allowed Per Diem Billing Rate is the amount derived from the rate setting process, as defined in Sections 1002.2 and 1002.3.

c. A nursing facility is an institution licensed and regulated to provide skilled care, intermediate care,



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or intermediate care services for the mentally retarded in accordance with the provisions of this Manual. For reimbursement purposes, effective October 1, 1990, nursing facilities including hospital based facilities are divided into four types based upon the mix of Medicaid patients residing in the facilities on September 30, 1990, and after. The type classification of a nursing facility may change as described in this chapter. The types are described below:

1. Level I Nursing Facilities - These facilities provide skilled and intermediate nursing care continuously, but do not provide constant medical and support services available in an acute care facility or hospital. At least 60% of Medicaid patients in these facilities receive skilled level of care services.

2. Level II Nursing Facilities - These facilities are often referred to as intermingled care and provide skilled and intermediate nursing care on a continuous basis. Skilled level of care services are provided for up to 60% of Medicaid patients in these facilities.

3. Intermediate Care Facilities for the Mentally Retarded (ICF-MR) - These facilities provide care to patients that are mentally retarded.

d. Cost Center refers to one of five groupings of expenses reported on Schedule B-2 of the "Nursing Home Cost Report Under Title XIX," hereinafter referred to as the Cost Report. Specifically, expenses for the five cost centers are reported in Column 3 of the Schedule as Routine and Special



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Services (Lines 17 and 77), Dietary (Line 89), Laundry and Housekeeping and Operation and Maintenance of Plant (Lines 109 and 123), Administrative and General (Line 169), and Property and Related (Line186). See hospital-based and state institutions cost reports for appropriate cost center expense groupings.

e. Distinct Part Nursing Facilities are facilities in which a portion operates as a Level I or Level II nursing facility and another portion operates separately as an intermediate care facility for the mentally retarded.

f. Total Patient Days are the number of days reported by the facility on Schedule A, Line 13, Column 8 of the Cost Report subject to correction or adjustment by the Division for incorrectly reported data.

g. Hospital-Based Nursing Facilities - A nursing facility is hospital-based when the following conditions are met:

1) The facility is affiliated with an acute care hospital that is enrolled with the Division in the Hospital Services Program.

2) The facility is subordinate to the hospital and operated as a separate and distinct hospital division which has financial and managerial responsibilities equivalent to those of other revenue producing divisions of the hospital.

3) The facility is operated with the hospital under common ownership and governance. The long-term care facility, as a division of

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the hospital, must be responsible to the hospital's governing board.

4) The facility is financially integrated with the hospital as evidenced by the utilization of the hospital's general and support services. A minimum of four services from Section A and two services from Section B below must be shared with the hospital.

Section A

a employee benefits
b) central services and supply
c) dietary
d) housekeeping
e) laundry and linen
f) maintenance and repairs

Section B

a) accounting
b) admissions
c) collections
d) data processing
e) maintenance of personnel

Facilities must provide organizational evidence demonstrating that the above requirements of 4) have been met. This evidence will be used to determine which facilities will be hospital-based.

Evidence that the required number of services in Sections A and B are shared with the hospital must be



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included in the hospital's Medicare cost report.

Appropriate costs should be allocated to the nursing home and the Medicare cost report must be approved by the Medicare intermediary.

In making the determination that a long-term care facility is hospital-based, collocation is not an essential factor; however, the distance between the facilities must be reasonable as determined by the Division or its agents.

The Division will recover the monetary difference reimbursed to the facility between hospital-based and freestanding status for any time period the facility does not qualify for hospital-based status.

To change classification to hospital-based from another class, or to enroll in the program as a hospital-based provider, the following restrictions apply in addition to the requirements described above:

(A) Only one hospital-based nursing facility per hospital is allowed.

(B) Any cost increases for the change to the hospital-based classification will be



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reimbursed when the first filed Medicare cost report is used to file the Medicaid cost report to set a per diem rate.

Nursing facilities classified as hospital-based prior to July 1, 1994, will be exempt from the above additional requirements. Hospitals which currently have more than one hospital-based nursing facility will not be allowed to include any additional hospital-based facilities.

h. Property Transaction is the sale of a facility or of a provider; the lease of a facility; the expiration of a lease of a facility; the construction of a new facility; an addition to the physical plant of a facility; or any transaction, other than change of ownership of a provider due solely to acquisition of capital stock, or the merger of a provider with another legal entity (statutory merger). For purposes of reimbursement, a sale shall not include any transaction in which acquisition is less than 51% of a partnership or proprietorship, or accomplished solely by acquisition of the capital stock of the corporation without acquisition of the assets of that corporation. The effective date of any Property Transaction shall be the latest of all of the following events which are applicable to the transaction:

1. The effective date of the sale or the lease.

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2. The first day a patient resides in the facility.

3. The date of the written approval by the Division of Health Planning of the relevant proposal.

4. The effective date of licensing by the Georgia Department of Human Resources Standards and Licensure Unit.

5. The effective date of the Statement of Participation in the Georgia Medical Assistance Program.

6. The date on which physical construction is certified complete by whichever agency(ies) is/are responsible for this determination.

7. The date of the approval of a Certificate of Need by the Division of Health Planning.

i. Gross Square Footage is the outside measurement of everything under a roof which is heated and enclosed. When the Division issues the provider a rate under the Dodge Index Property System, it is a tentative rate based upon the data previously submitted to the Division for verification. The data received on gross square footage and age of a facility are subject to audit review (along with other parameters which affect the billing rate calculation). Documentation should include but not be

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limited to blueprints, architect plans, certified appraisals, etc.

j. Age is the original date a building was completed counted by years through December, 1983 with no partial year calculations. For facilities with buildings constructed in different years, the composite age of the facility is computed using the number of square feet contained in each unit to produce a weighted average age.

k. Cost is the expense incurred for goods and services used to operate a nursing facility. In the establishment of a per diem billing rate, most costs are allowable while certain other costs are not. A definition of cost and a discussion of allowable and non-allowable costs is contained in Centers for Medicare and Medicaid Services Provider Reimbursement Manual (CMS-15-1). In addition to those non-allowable costs discussed in CMS-15-1, the costs listed below are non-allowable.

- Costs related to lobbying and government relations, including costs for employees with duties related to lobbying and government relations, honorariums and reimbursement of travel or other expenses of elected officials;
- Memberships in civic organizations;
- Out-of-state travel paid by the provider for persons other than board



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members or those employed or contracted by the provider. Out-of-state travel for provider personnel must be related to patient care;

- Vehicle depreciation or vehicle lease expense in excess of the lesser of IRS limits per vehicle or the amount allowed under Medicare reimbursement principles provided, however, such limits shall not apply to specialized patient transport vehicles (e.g. ambulances);

- Air transport vehicles that are not used to transport patient care staff or patients. If these vehicles are sometimes used for patient care staff or patient transport, the portion of cost that is unrelated to patient care staff or patient transport is non-allowable. For purposes of this provision, patient care staff includes only those who are transported in order to provide direct medical care to an individual patient.

- Fifty percent (50%) of membership dues for national, state, and local associations;

- Legal services for an administrative appeal or hearing, or court proceedings involving the provider and the Division or any other state agency when a judgement or relief is not granted to the provider. Legal services associated with certificate of



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